

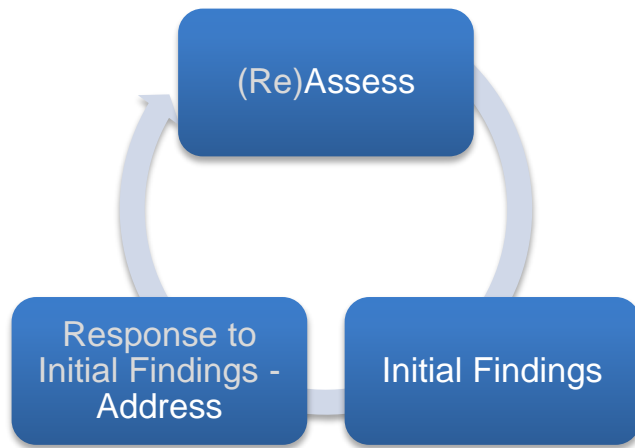
*Subject Area Committee Name:* Emergency Medical Services (EMS)

*Focal Outcome Being Reassessed:* Effectiveness of Integrated Out-of-Hospital Scenarios

*Contact Person:*

<i>Name</i>	<i>e-mail</i>
Jackilyn Williams	jackilyn.cypher@pcc.edu

Use this form if your assessment project is a follow-up reassessment of a previously completed initial assessment. The basic model we use for core outcome assessment at PCC is an “assess – address – reassess” model.



The primary purpose for yearly assessment is to improve student learning. We do this by seeking out areas of concern, making changes, reassessing to see if the changes helped.

- Refer to the help document for guidance in filling out this report. If this document does not address your question/concern, contact [Wayne Hooke](#) to arrange for coaching assistance.
- Please attach all rubrics/assignments/etc. to your report submissions.
- **Subject Line of Email:** Reassessment Report Form (or RRF) for <your SAC name> (Example: RRF for NRS)
- **File name:** SACInitials\_RRF\_2016 (Example: NRS\_RRF\_2016)
- SACs are encouraged to share this report with their LAC coach for feedback before submitting.
- Make all submissions to [learningassessment@pcc.edu](mailto:learningassessment@pcc.edu).

**Due Dates:**

- **Planning Sections of LAC Assessment or Reassessment Reports: November 28<sup>th</sup>, 2016**
- **Completed LAC Assessment or Reassessment Reports: June 16<sup>th</sup>, 2017**

*Please Verify This Before Beginning this Report:*

- This project is in the second stage of the assess/reassess process (if this is an initial assessment, use the LAC Assessment Report Form CTE. Available [here](#).)*

**Initial Assessment Project Summary (previously completed assessment project)**

*Briefly summarize the main findings of your **initial** assessment. Include either 1 ) the frequencies (counts) of students who attained your benchmarks and those who did not, or 2) the percentage of students who attained your benchmark(s) and the size of the sample you measured:*

The initial assessment included the entire 2014 program population (n24). At that time, the population meeting summative simulation benchmarks = 24 (100%); population not meeting benchmarks = 0. It needs to be noted that the initial assessment was an in-progress assessment, not complete. One reassessment has already been reported, the 2014-2015 program population (n24), again, it needs to be noted that the reassessment reported on was also an in-progress assessment, meaning no data was available to report in June for that year, as the program runs on a calendar year, not academic year. The program is including the 2016-2017 report, also as a reassessment, because this outcome was not the focal reassessment reported on for 2015-2016. We can report data captured during the 2015-2016 reassessment to get a clear picture of outcomes now.

*Briefly summarize the changes to instruction, assignments, texts, lectures, etc. that you have made to address your initial findings:*

There were no changes between the initial reporting (2013-2014) and the first reassessment reporting (2014-2015). The initial reporting was an in-progress assessment, and final results were not available until Feb. 2015. The first reassessment reporting also had no data to report until approximately May 2016. The paramedic program runs on a calendar year, not an academic year, so we are not able to report complete summary data in a June report. Both times we were seeing indications of positive progression & attainment of outcomes, hence did not want or need to make changes until all data was available.

March 2016, the program began using the new national Paramedic Psychomotor Competency Portfolio (PPCP) required of every paramedic student nationwide as of August 2016. The PPCP is required for any paramedic student beginning a paramedic program on or after August, 2016. That did not include the 2016 PCC Paramedic Cohort, which began January 2016. The PPCP includes the simulation scenarios that the program is evaluating for the focal analysis. The change to instruction is the program is now held to the PPCP for every student, or they will not be eligible to sit for the certification exam (the licensing exam for Oregon).

*If you initially assessed students in courses, which courses did you assess:*

Our initial report (2013-2014) included Spring Term 2014 (EMS 242 & EMS 244). EMS 242 is a Didactic/Skills Lab Course; EMS 244 is Clinical (Hospital) Rotations with a weekly Skills Lab component. At the time the initial report was submitted (June 2014), we were looking at incomplete data, as we were looking for summary data from the entire program, not just a few courses. This was the case with the 2014-2015 reassessment. This focal analysis was not reported on for 2015-2016, although it was evaluated for national accreditation purposes.

*If you made changes to your assessment tools or processes for this reassessment, briefly describe those changes here:*

Beginning in March 2016, the program changed how student outcomes were documented. Platinum Planner, an online EMS documentation platform, was set-up for the paramedic program, which allows all student competencies to be captured in a useful manner. Many report options are now available to us to facilitate data analysis. Platinum Planner was initiated in response to the need to document the national Paramedic Psychomotor Competency Portfolio (PPCP) required of every paramedic student nationwide. The PPCP includes the simulation scenarios that the program is evaluating for the focal analysis. The biggest change has been to the use of the PPCP's simulation evaluation instruments, rather than continued use of the program-generated instruments.

## 1. Outcome Chosen for Focal Analysis

### 1A. How does your field interpret the outcome you are reassessing?

Initially the outcome being assessed was only a program standard, but quickly became a national standard for paramedic training. It is now a national standard that is a component of the Paramedic Psychomotor Competency Portfolio (PPCP) which includes all paramedic skills, as well as simulated patient encounters, now referred to as Integrated out-of-hospital (IOOH) scenarios. The simulation outcomes being reassessed at PCC are now in alignment with the IOOH scenarios. The IOOH scenarios must be passed to be eligible to take the paramedic licensing exam. We originally wanted to assess how effective our simulation program was for student success in clinical & field rotations. Now our focus has shifted slightly to how effective the IOOH scenarios are to student success at the program capstone event, after clinical & field rotations.

### 1B. If the assessment project relates to any of the following, check all that apply:

- Degree/Certificate Outcome – if yes, include here: Act in accordance with the ethical & professional medical standards of the entry level paramedic; Meet the academic eligibility requirements for taking both cognitive and practical State and National Certification examinations at the Paramedic level.
- PCC Core Outcome – if yes, which one: Critical Thinking & Problem Solving, Professional Competence, Self-Reflection
- Course Outcome – if yes, which one: Ability to progress from simple to complex scenario-based training applying cognitive & psychomotor skills.

## 2. Project Description

### 2A. Assessment Context

Check all the applicable items:

**Course-based assessment.**

Course names and number(s): Paramedic II, EMS 242; Paramedic Clinical Internship I/II, EMS 244/246; Paramedic Field Internship I/II, EMS 248/250; Paramedic III EMS 252 (Capstone Course)

Type of assessment (e.g., essay, exam, speech, project, etc.): Summative Simulation Scenarios

Are there course outcomes that align with this aspect of the core outcome being investigated?  Yes  No

If yes, include the course outcome(s) from the relevant CCOG(s): EMS 242: The student will be able to: 5. Synthesize facts and principles from the psychosocial sciences in describing the unique challenges in dealing with themselves, adults, children, and other special populations when faced with a death and dying situation. EMS 244/246: The student will:

3. Effectively communicate in a self-directed manner with persons of diverse cultural backgrounds and roles in a variety of settings.

4. Demonstrate ethical and legal responsibilities in regard to health care

7. Develop a plan of care based on the patient's history and physical exam, develop a problem list, and identify the appropriate intervention for each problem.

8. Solicit and utilize the preceptor's feedback to improve performance

9. Meet potential employer expectations by developing an appropriate resume and demonstrating well-developed interview skills.

EMS 248/250: The student will:

2. Gain a working knowledge of the EMS system he/she is assigned to, and or Oregon's EMS system in general.

8. Solicit and utilize the preceptor's feedback to improve performance.

EMS 252: The student will:

1. Demonstrate synthesizing facts and principles from the biophysical-psychosocial science throughout human development in the assessment and communication process for patients of all ages.

3. Identify the paramedic role within the health care system and serve as a healthy role model for public, peers and other health care professionals.

7. Demonstrate effective communication with peers and direction of a medical team during emergency medical care procedures.

9. Demonstrate accurate and succinct written and/or oral reporting with regards to patient care.

**Common/embedded assignment in all relevant course sections.** An embedded assignment is one that is already included as an element in the course as usually taught. Please attach the activity in an appendix. If the activity cannot be shared, indicate the type of assignment (e.g., essay, exam, speech, project, etc.): **Paramedic Psychomotor Competency Portfolio (PPCP)-this document is too large to share (168 pages). It contains all the required psychomotor skills & scenario lab instruments, including evaluation tools & rubrics (both formative & summative). Appendix G & H are samples from the PPCP. TEAM MEMBER EVALUATION-SCENARIO LAB, TEAM LEADER EVALUATION-SCENARIO LAB (Appendix G); How to Use Scenario Lab Instruments/Rubric (Appendix H); Global Affective Professional Behavior Evaluation (Appendix A); Field Preceptor Statement of Entry-Level Competency (Appendix C); Medical Director Statement of Entry-Level Competency (Appendix D). Platinum Planner is used throughout the program to evaluate and document student competency, it is a live platform and**

**samples are included as: Appendix B-SAMPLE Platinum Planner Student Progress Report; Appendix E-SAMPLE Platinum Planner Clinical/Field Affective Evaluation.**

**Common – but not embedded - assignment used in all relevant course sections.** Please attach the activity in an appendix. If the activity cannot be shared, indicate the type of assignment (e.g., essay, exam, speech, project, etc.):

**Practicum/Clinical work.** Please attach the activity/checklist/etc. in an appendix. If this cannot be shared, indicate the type of assessment (e.g., supervisor checklist, interview, essay, exam, speech, project, etc.): **PPCP as above, and documented in Platinum Planner (online documentation), which is completed by both student and clinical/field preceptors from hospitals/ambulance agencies. Platinum Planner is a live document that cannot be shared. Samples of the reports generated are included as Appendix B - SAMPLE Platinum Planner Student Progress Report and Appendix E - SAMPLE Platinum Planner Clinical/Field Affective Evaluation**

**External certification exam.** Please attach sample questions for the relevant portions of the exam in an appendix (provided that publically revealing this information will not compromise test security). Also, briefly describe how the results of this exam are broken down in a way that leads to nuanced information about the aspect of the core outcome that is being investigated. National Registry of Emergency Medical Technician-Paramedic (NREMT-P) Cognitive & Psychomotor Examinations. Not authorized to provide sample questions. All aspects of the examination must be completed as a "pass" (competent entry-level). If any aspect is failed, then graduates are not entry-level competent. This is the licensing exam for the State of Oregon (as well as all the other states). The exams are broken down into subject areas, and each area must be passed and/or completed as competent, as well as an over-all passing score/evaluation. We can trend repeated missed subject areas only for nuanced information. We can also compare PCC graduate performance against other paramedic graduates in Oregon, as well as against all other paramedic graduates nationwide. The psychomotor component of the exam now includes the Integrated Out-of-Hospital (IOOH) scenarios for the first time beginning January 1, 2017.

**SAC-created, non-course assessment.** Please attach the assessment in an appendix. If the assessment cannot be shared, indicate the type of assignment (e.g., essay, exam, speech, project, etc.):

**Portfolio.** Please attach sample instructions/activities/etc. for the relevant portions of the portfolio submission in an appendix. Briefly describe how the results of this assessment are broken down in a way that leads to nuanced information about the aspect of the core outcome that is being investigated:

**TSA.** Please attach the relevant portions of the assessment in an appendix. If the assessment cannot be shared, indicate the type of assignment (e.g., essay, exam, speech, project, etc.):

**Test with Industry Recognized Certificate or License (TESTIRCL\*\*)**

- Survey**
- Interview**
- Other.** Please attach the activity/assessment in an appendix. If the activity cannot be shared, please briefly describe:

In the event publicly sharing your assessment documents will compromise future assessments or uses of the assignment, do not attach the actual assignment/document. Instead, please give as much detail about the activity as possible in an appendix.

*2B. How will you score/measure/quantify student performance?*

- Rubric** (used when student performance is on a continuum - if available, attach as an appendix – if in development, attach to the completed report that is submitted in June)
- Checklist** (used when presence/absence rather than quality is being evaluated - if available, attach as an appendix – if in development, attach to the completed report that is submitted in June)
- Trend Analysis** (often used to understand the ways in which students are, and are not, meeting expectations; trend analysis can complement rubrics and checklist)
- Objective Scoring** (e.g., Scantron-scored examinations)
- Other** – briefly describe:

*2C. Type of assessment (select one per column)*

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> <b>Quantitative</b> | <input checked="" type="checkbox"/> <b>Direct Assessment</b> |
| <input type="checkbox"/> <b>Qualitative</b>             | <input type="checkbox"/> <b>Indirect Assessment</b>          |

If you selected 'Indirect Assessment', please share your rationale:

Qualitative Measures: projects that analyze in-depth, non-numerical data via observer impression rather than via quantitative analysis. Generally, qualitative measures are used in exploratory, pilot projects rather than in true assessments of student attainment. Note that the **use of a numerical rubric is considered quantitative analysis**, even if the artifacts under consideration are not based on quantitative evaluations (e.g. an essay scored by a rubric counts as quantitative in the context of assessment).

Indirect assessments (e.g., surveys, focus groups, etc.) do not use measures of direct student work output. These types of assessments are also not able to truly document student attainment.

*2D. Check any of the following that were used by your SAC to create or select the assessment/scoring criteria/instruments used in this project:*

- Committee or subcommittee of the SAC collaborated in its creation
- Standardized assessment
- Collaboration with external stakeholders (e.g., advisory board, transfer institution/program)
- Theoretical model (e.g., Bloom's Taxonomy)
- Aligned the assessment with standards from a professional body (for example, The American Psychological Association Undergraduate Guidelines, etc.)
- Aligned the benchmark with the Associate's Degree-level expectations of the Degree Qualifications Profile
- Aligned the benchmark to within-discipline post-requisite course(s)
- Aligned the benchmark to out-of-discipline post-requisite course(s)
- Other (briefly explain: Aligned the benchmarks to comply with national accreditation standards for paramedic programs & program benchmarks)

2E. In which quarter will student artifacts (samples of student work) be collected? If student artifacts will be collected in more than one term, check all that apply.

- Fall**    **Winter**    **Spring**    **Other** (e.g., if work is collected between terms)

2F. What student group do you want to generalize the results of your assessment to? For example, if you are assessing performance in a course, the student group you want to generalize to is 'all students taking this course.'

The entire cohort of current paramedic degree program

2G. There is no single, recommended assessment strategy. Each SAC is tasked with choosing appropriate methods for their purposes. Which best describes the purpose of this project?

- To measure established outcomes and/or drive programmatic change**
- To participate in the Multi-State Collaborative for Learning Outcomes Assessment**
- Preliminary/Exploratory Investigation**

If you selected 'Preliminary/Exploratory', briefly describe your rationale for selecting your sampling method:

2H. Which will you measure?



- the population** (all relevant students – e.g., all students enrolled in all currently-offered sections of the course)
- a sample** (a subset of students)

If you are using a sample, select all of the following that describe your sample/sampling strategy (refer to the Help Guide for assistance):

- Random Sample** (student work selected completely randomly from all relevant students)
- Systematic Sample** (student work selected through an arbitrary pattern, e.g., 'start at student 7 on the roster and then select every 5<sup>th</sup> student following'; repeating this in all relevant course sections)
- Stratified Sample** (more complex, consult with an LAC coach if you need assistance)
- Cluster Sample** (students are selected randomly from meaningful, naturally-occurring groupings (e.g., SES, placement exam scores, etc.))
- Voluntary Response Sample** (students submit their work/responses through voluntary submission – e.g., via a survey)
- Opportunity/Convenience Sample** (only some of the relevant instructors are participating)

The last three options in bolded red have a high risk of introducing bias. If your SAC is using one or more of these sample/sampling strategies, please share your rationale:

*2J. Briefly describe the procedure you will use to select your sample (including a description of the procedures used to ensure student and instructor anonymity).*

The entire cohort is being used

*2K. Follow this link to determine how many artifacts (samples of student work) you should include in your assessment: <http://www.raosoft.com/samplesize.html> (see screen shot below).*

*Start with the number of students you estimate will be enrolled in the course(s) from which you will draw the sample – that is your “population.” Enter the other numbers as indicated in the screenshot. The sample size calculator will tell you how many artifacts you need to collect. Enter that number below:*

**Sample size calculator**

What margin of error can you accept?  
5% is a common choice

10 %

What confidence level do you need?  
Typical choices are 90%, 95%, or 99%

90 %

What is the population size?  
If you don't know, use 20000

105

What is the response distribution?  
Leave this as 50%

50 %

Your recommended sample size is

42

*Handwritten annotations:*  
 - Red arrows point from the 10% margin of error field to the text: "The margin of error is the amount of error that you can tolerate. If 90% of respondents answer yes, while 10% answer no, you may be able to tolerate a larger amount of error than if the respondents are split 50-50 or 45-55. Lower margin of error requires a larger sample size. Use 10% and 90% in these boxes."  
 - Red arrows point from the 90% confidence level field to the text: "The confidence level is the amount of uncertainty you can tolerate. Suppose that you have 20 yes-no questions in your survey. With a confidence level of 95%, you would expect that for one of the questions (1 in 20), the percentage of people who answer yes would be more than the margin of error away from the true answer. The true answer is the percentage you would get if you exhaustively interviewed everyone. Higher confidence level requires a larger sample size. Enter the total number of students currently enrolled in all sections of the courses you are assessing here."  
 - Red arrows point from the 50% response distribution field to the text: "For each question, what do you expect the results will be? If the sample is skewed highly one way or the other, the population probably is, too. If you don't know, use 50%, which gives the largest sample size. See below under More information if this is confusing. Measure this many students."  
 - A red box highlights the final recommended sample size of 42.

### 3. Project Mechanics

3A. Does your project utilize a rubric for scoring?  Yes  No

If 'No', proceed to section B. If 'Yes', complete the following:

Which method of ensuring consistent scoring (inter-rater reliability) will your SAC use for this project?

**Agreement** – the percentage of raters giving each artifact the same/similar score in a norming session; ideally, that will be 75% agreement or greater.

If you are using agreement, describe your plan for plan for conducting the “norming” or “calibrating” session:

The Paramedic Psychomotor Competency Portfolio (PPCP) Manual provides examples of how to implement all of the evaluation tools into paramedic education and provides standards that comprise the current research regarding the acquisition of psychomotor competency. The PPCP is a compilation of best practices in education, measurement, and documentation of psychomotor

competency. The standards, rubrics & examples in the PPCP are designed to help improve inter-rater reliability by attaching minimum standards and helping to standardize the evaluation of skill performances. The instruments and methods used to facilitate consistent recording of student performances and instructions to the evaluators focus on improving inter-rater reliability. The program uses the PPCP Manual, as well as video based preceptor training imbedded in Platinum Planner to achieve 100% (or very close to 100%) consistency during norming sessions. Raters must achieve a minimum of 95% accuracy or receive additional guidance on use of the instruments/tools. 100% of raters gave all aspects of the evaluations the same or very similar scores at the conclusion of the same/similar norming sessions (100% Agreement)

**Consensus** - all raters score all artifacts and reach agreement on each score

**Consistency\*** – raters' scores are correlated: this captures relative standing of the performance ratings - but not precise agreement. Briefly describe your plan:

**Notes:** the agreement method is the most frequently used for assessment, but the **calculation of inter-rater reliability is also among the more challenging issues** within assessment as a whole. If your SAC is unfamiliar with norming procedures, contact your assessment coach, or if you don't know who your coach is, contact LAC Vice Chair [Chris Brooks](#) to arrange for coaching help for your SAC's norming session.

The consistency method is not generally recommended; see the help guide for details.

### *3B. Have performance benchmarks been specified?*

The fundamental measure in educational assessment is the number of students who complete the work at the expected/required level. We are calling this SAC-determined performance expectation the 'benchmark.'

- Yes**  
 **No**

If yes, briefly describe your performance benchmarks, being as specific as possible (if needed, attach as an appendix):

Performance benchmarks minimums are suggested by paramedic national accreditation standards, and by the national testing body (NREMT). NREMT minimums in the Paramedic Psychomotor Competency Portfolio have to be met 100% ("Pass") by 100% of the students, to be allowed to test the national certification exam. The additional suggested benchmarks by national accreditation

standards are used as a starting point for the program to set the numbers, and then those numbers are endorsed by the program advisory committee on an annual basis. The benchmark numbers may be re-set according to program review/evaluation by the program director/instructor, and/or input from the advisory committee.

NREMT-P Exam = Pass within 1 yr. of program completion  
 Global Affective Evaluation = "Competent" in all categories at the conclusion of each course & at program completion  
 Clinical Shift Evaluation = "3" rating using a 1-3 Likert Scale (Platinum Planner)  
 Field Internship Shift Evaluation = "3" rating using a 1-3 Likert Scale (Platinum Planner)  
 Clinical/Field Affective Evaluation = "3" or higher rating using a 1-5 Likert Scale (Platinum Planner)  
 Simulation Summative Performance = "Competent" score within 3 attempts (Platinum Planner)  
 Patient Care Report Documentation = Required ALS Calls (40/40) & Team Leads (50/50) have been met (Platinum Planner)  
 Field Preceptor & Medical Director Statement of Entry-Level Competency = "Competent as Entry-Level" by both at program completion

If no, what is the purpose of this assessment? (For example, this assessment will provide information that will lead to developing benchmarks in the future; or, this assessment will lead to areas for more detailed study, etc.)

3C. The purpose of this assessment is to have SAC-wide evaluation of student work, not to evaluate a particular instructor or student. Before evaluation, remove student-identifying information (and, when possible remove instructor-identifying information). If the SAC wishes to return instructor-specific results, see the Help Guide for suggestions on how to code and collate. **Please share your process for ensuring that all identifying information has been removed.**

There is no student identifying information included in this report, only overall result numbers are being reported. As only one FT Faculty instructs the program cohort, anonymity of instructors doesn't apply.

3D. Will you be coding your data/artifacts in order to compare student sub-groups?  Yes  No

If yes, select one of the boxes below:

student's total earned hours  previous coursework completed  ethnicity  other

Briefly describe your coding plan and rationale (and if you selected 'other', identify the sub-groups you will be coding for):

3E. Ideally, student work is **evaluated** by both full-time and adjunct faculty, even if students being assessed are taught by only full-time and/or adjunct faculty. Further, more than one rater is needed to ensure inter-rater reliability. If you feel only one rater is feasible for your SAC, please explain why:

Who will be assessing student work for this project? Check all that apply.

- PCC Adjunct Faculty within the program/discipline
- PCC FT Faculty within the program/discipline
- PCC Faculty outside the program/discipline
- Program Advisory Board Members
- Non-PCC Faculty
- External Supervisors
- Other:

***End of Planning Section – Complete the remainder of this report after your assessment project is complete.***

***Beginning of End-of-Year Reporting Section – complete the following sections after your reassessment project is complete.***

4. *Changes to the Assessment Plan*

*Have there been changes to your project since you submitted the planning section of this report?*  **Yes**

**No**

If so, summarize those changes below:

5. *Narrative*

*Broadly, what did your SAC learn this year from the assessment of the selected core outcome?*

*The paramedic program runs on a calendar year, not an academic year, so reporting results for a cohort in June is challenging for us. Interpretation for attainment of the core outcomes is not possible until all data has been obtained at the end of the calendar year. This 2016-2017 reassessment report completes the reassessment data for the 2016 cohort, but does not include data on the 2017 cohort. The SAC can, however, interpret results from the 2017 Spring Term data only, as an indicator of positive progression of the overall project to its conclusion. Data from 2017 Spring Term have been collected and evaluated, but have not been documented elsewhere in this report. Those Spring Term results are in line with the data being reported on, with 100% (n21) of the students attaining desired results. Results at the end of Spring Term have historically proven to be consistent with results at the end of the program. The SAC conclusions are that the new Integrated Out-of-Hospital (IOOH) Scenario requirements for all paramedic students nationwide are very similar to what our program has been requiring of our paramedic students for several years now.*

6. Results of the Analysis of Assessment Project Data

6A. Quantitative Summary of Sample/Population

How many students were enrolled in all sections of the course(s) you assessed this year? 22

If you did not assess in a course, report the number of students that are in the group you intend to generalize your results to.

How many students did you actually assess in this project? 22

Did you use a recommended sample size (see the Sample Size Calculator linked to in section 2J)?

Yes  No

If you did not use a recommended sample size in your assessment, briefly explain why:

Entire cohort was used (n22)

6B. Did your project utilize a rubric for scoring?  Yes  No

If 'No', proceed to section C. If 'Yes', complete the following:

How was inter-rater reliability assured? (Contact your SAC's LAC Coach if you would like help with this.)

- Agreement** – the percentage of raters giving each artifact the same/similar score in a norming session
- Consensus** - all raters score all artifacts and reach agreement on each score
- Consistency** – raters' scores are correlated: this captures relative standing of the performance ratings - but not precise agreement
- Inter-rater reliability was not assured.**

If you utilized agreement or consistency measures of inter-rater reliability, report the level here:

95-100% in agreement

6C. Brief Summary of Benchmark Achievement (frequencies and/or averages)

In most cases, report the numbers of students who attain your benchmark level and the numbers who do not. **Do not average these numbers or combine dissimilar categories (e.g., do not combine ratings**

**for communication and critical thinking together).** *If your project measures how many students attain the overall benchmark level of performance, report the summary numbers below (choose one):*

- 1. If you used frequencies of benchmark achievement, report those here. For example, “46 students attained or exceeded the benchmark level in written communication and 15 did not.” If necessary, provide detailed results in an appendix.*

Outcomes for the 2016 Cohort: The NREMT EXAM during 2016 did not include the Integrated Out-of-Hospital (IOOH) Scenarios. Not all of the 2016 cohort tested prior to January 1, 2017 when the exam changed to include the IOOH.

1. Non-IOOH NREMT exam results: 10/10 successful, 0/10 unsuccessful.
2. IOOH NREMT exam results: 12/12 successful, 0/12 unsuccessful, (total cohort n22)
3. Global Affective Eval: 22/22 successful, 0/22 unsuccessful
4. Clinical/Field Affective Eval: 22/22 successful, 0/22 unsuccessful
5. Clinical Shift Eval: 22/22 successful, 0/22 unsuccessful
6. Field Internship Shift Eval: 22/22 successful, 0/22 successful
7. Simulation Summative Performance: 22/22 successful, 0/22 unsuccessful
8. Patient Care Report Documentation: 22/22 successful, 0/22 unsuccessful
9. Field Preceptor & Medical Director Statement of Entry-Level Competency: 22/22 successful, 0/22 unsuccessful

As all of the summary numbers are successful in all categories, no actual student evaluations are included. It should be noted that the results of the core outcomes being measured (Critical Thinking & Problem Solving, Professional Competence and Self Reflection) HAVE been combined in this report, as the results of each evaluation is the same. This has been done for ease of reporting and simplification of results review.

- 2. If you used percentages of the total to identify the degree of benchmark attainment in this project, report those here. For example, “75% of 61 students attained or exceeded the benchmark level over-all in written communication.”*
- 3. Compare your students’ attainment of your expectations/benchmarks in this reassessment with their attainment in the initial assessment. Briefly summarize your conclusions.*



100% (n24) attained the desired results in the initial assessment, 100% (n22) attained the desired results in the reassessment. With the inclusion of the Integrated Out-of-Hospital (IOOH) Scenario in the NREMT certifying/licensing exam affecting the 2016 cohort, the results are very encouraging. The students taking the exam prior to inclusion of the IOOH were as expected at 100%. The remainder of the cohort that tested after the January 1, 2017 change that included the IOOH were a pleasant affirmation of student success on Summative Simulation Evaluations, even using a newer evaluation instrument. Consistent feedback from simulation scenario raters (experienced paramedics) encouraged effective self-directed improvement of critical thinking and problem solving skills with simulated patients, family members/bystanders, other medical professionals and potential preceptors. Formative simulation scenarios allowed students to tailor their improvement goals to their individual learning needs. At the end of each formative simulation scenario, the student is asked for 2 goals to improve on during the next simulation. Simulation scenarios during both the initial assessment and the reassessment showed attainment of learning goals, showing consistent improvement from simple to complex critical thinking/problem solving skills, professionalism & self-reflexion skills. This shows that use of the new IOOH evaluation instrument during simulation scenarios throughout the program, and at the conclusion of the program, is meeting our expectations as hoped.

*6D. If possible, attach a more detailed description or analysis of your results (e.g., rubric scores, trend analyses, etc.) as an appendix to this document. Appendix attached?  Yes  No*

*6E. Do the results of this project suggest that additional academic / training changes might be beneficial to your students (changes in curriculum, content, materials, instruction, pedagogy etc.)?  Yes  No*

*If you answered 'Yes,' briefly describe the changes to improve student learning below. If you answered 'No', detail why no changes are called for.*

Results do not suggest academic changes are needed, however we will continue to monitor results for effectiveness.

*If you are planning changes, when will these changes be fully implemented?*

If we determine changes would be required at the end of the calendar year, new changes would be implemented prior to the beginning of the next cohort in January 2018.

6F. Has all identifying information been removed from your documents? (Information includes student/instructor/supervisor names/identification numbers, names of external placement sites, etc.)  Yes  No

7. SAC Response to the Assessment Project Results

7A. Assessment Tools & Processes: Indicate how well each of the following worked for your assessment:

Tools (rubrics, test items, questionnaires, etc.):

very well    some small problems/limitations to fix    notable problems/limitations to fix    completely inadequate/failure

Please comment briefly on any changes to assessment tools that would lead to more meaningful results if this assessment were to be repeated (or adapted to another outcome).

The assessment tools and processes used have proven to be highly effective and do not require revision at this time. We will continue to monitor results for effectiveness.

Processes (faculty involvement, sampling, norming, inter-rater reliability, etc.):

very well    some small problems/limitations to fix    notable problems/limitations to fix    tools completely inadequate/failure

Please comment briefly on any changes to assessment process that would lead to more meaningful results if this assessment were to be repeated (or adapted to another outcome).

No changes are needed at this time.

8. Follow-Up Plan

8A. How will the changes detailed in this report be shared with all FT/PT faculty in your SAC? (select all that apply)

- |  |  |   |
|--|--|---|
| <input checked="" type="checkbox"/> email    | <input type="checkbox"/> phone call                      | <input type="checkbox"/> workshop         |
| <input type="checkbox"/> campus mail         | <input checked="" type="checkbox"/> face-to-face meeting | <input checked="" type="checkbox"/> other |
| <input type="checkbox"/> no changes to share |  |   |

If 'other,' please describe briefly below.

Fall SAC meeting will include details of report with a review of assessment processes

8B. Is further collaboration/training required to properly implement the identified changes?  Yes  No

If 'Yes,' briefly detail your plan/schedule below.

8C. Sometimes reassessment projects call for additional reassessments. These can be formal or informal. How will you assess the effectiveness of the changes you plan to make?

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> follow-up project in next year's annual report | <input checked="" type="checkbox"/> on-going informal assessment |
| <input type="checkbox"/> in a future assessment project                            | <input type="checkbox"/> other                                   |

If 'other,' please describe briefly below.

8D. SACs are learning how to create and manage meaningful assessments in their courses. This development may require SAC discussion to support the assessment process (e.g., awareness, buy-in, communication, etc.). Please briefly describe any successful developments within your SAC that support the quality assessment of student learning. If challenges remain, these can also be shared.

Our SAC has been creating and managing meaningful assessments in our courses for many years. The culture of our SAC has always been one of experienced collaboration with productive communication that has worked very well to this point. The SAC does not anticipate changes, but will continue to monitor our effectiveness through continued frequent communication and re-evaluation.

